DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **03-011**

2. STATE: **NC**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
Effective ~~May 1, 2003~~ Oct 1, 03
Pen & Ink Change per e-mail from SA

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN X AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.201

7. FEDERAL BUDGET IMPACT:
a. FFY 2004 $0.00
b. FFY 2005 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-B, Section 12, Page 3

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19-B, Section 12, Page 3

10. SUBJECT OF AMENDMENT:
Prosthetic and Orthotic Devices

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
X OTHER, AS SPECIFIED: Not Required

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Carmen Hooker Odom

13. TYPED NAME:
Carmen Hooker Odom

14. TITLE:
Secretary

15. DATE SUBMITTED:
12/4/03

16. RETURN TO:
Office of the Secretary
Department of Health and Human Services
2001 Mail Service Center
Raleigh, North Carolina 27699-2001

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: [illegible]

18. DATE APPROVED: [illegible]

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: [illegible]

20. SIGNATURE OF REGIONAL OFFICIAL: [illegible]

21. TYPED NAME: [illegible]

22. TITLE: [illegible]

23. REMARKS: [illegible]

MEDICAL ASSISTANCE
State: NORTH CAROLINA

PAYMENTS FOR MEDICAL AND REMEDIAL CARE AND SERVICE

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in disease of the eye or by an optometrist.

12.c. PROSTHETIC AND ORTHOTIC DEVICES

Payment for each claim for prosthetic/orthotic devices will be equal to the lower of the supplier's usual and customary billed charges or the maximum fee established for each item. The maximum fees are set at 100 percent of the Medicare Part B fees as of January 1 of each year. If a Medicare fee cannot be obtained for a particular item, the fee will be based on estimates of reasonable costs and updated each January 1 by the forecasted percentage increase in prices for the devices. **Notwithstanding any other provision, if specified these rates will be adjusted as shown on Supplement 4 to the Attachment 4.19-B section of the state plan.** There will be no retroactive payment adjustments for fee changes.

When devices are provided by state or local government agencies, reimbursement will not exceed the cost of the device.